EXHIBIT "N"

Emergency Expert Report
Keith A. Marill, M.D.

I have been asked to review 222 charts from Abington Memorial Hospital covering a four week period of time. These charts consist of the Emergency Department records of 221 patients other than Mr. Strimber who presented to the Abington Memorial Hospital Emergency Department with a complaint of chest pain. Specifically, you have asked me to review these charts in the context of whether the care provided to Mr. Strimber on February 22, 2012, demonstrates an inadequate screening evaluation under EMTALA. As noted in my previous report, I have reviewed all documents provided regarding the care of Mr. Strimber. In addition to the 221 charts, I have also reviewed a spreadsheet documenting the age, gender, chief complaint, chest x-ray, other chest imaging studies, and final diagnosis of all patients seen in the Abington Memorial Hospital Emergency Department with a chief complaint of chest pain from 2 weeks before to 2 weeks after the date Mr. Strimber presented, February 22, 2012. This spreadsheet is an accurate summary of the 222 charts.

According to the spreadsheet provided, 222 patients presented to the Abington Memorial Hospital with a triage chief complaint of chest pain during this period. 207 patients (93%) had a chest x-ray ordered, while 15 patients (including Mr. Strimber) did not have a chest x-ray ordered. With regard to the 14 patients other than Mr. Strimber, the reasons for not obtaining a chest x-ray vary as follows:

1. In 3 cases (MRN #'s 1072603, 1306027, 411351) a CT of the chest was ordered both with and without contrast, which is more sensitive and useful as a diagnostic tool than a plain film chest x-ray and thus a chest x-ray would have been superfluous.
2. In the case of MRN #1278443, the patient was a 42 year old male who was hit in the chest playing soccer and received an x-ray of his ribs in which his heart and lungs were visualized and reported as normal. A chest x-ray would have therefore been superfluous.
3. In the case of MRN #1161066, a STEMI was immediately diagnosed based upon EKG findings and the ED physician made arrangements for the patient to be taken immediately to the cardiac cath lab for appropriate intervention. Again, a chest x-ray in this case would have been superfluous because a diagnosis was made before arrival to the ED and a PCI alert was initiated. A chest x-ray is not indicated in this situation as it delays time critical transfer to the cardiac cath lab. The patient would subsequently receive cardiac and chest imaging in the cath lab by the cardiologist via fluoroscopy films.
4. In the case of MRN #5052201, a 23 year old male presented with epigastric pain reported to the triage nurse that felt the same as a previous gallbladder attack. An abdominal ultrasound was performed and showed cholelithiasis (gallstones). In the case of a 23 year old otherwise healthy individual with a confirmed diagnosis of cholelithiasis and known history of cholelithiasis, a chest x-ray would have been superfluous.
5. In the case of MRN #5053797, an otherwise healthy 48 year old female became "upset, nervous, and emotional" while in the waiting room waiting for the discharge of her daughter. She had no cardiac history and reported a history of chest discomfort when she gets stressed and worried. An EKG was normal. In light of the patient's lack of cardiac history, age, nature of the onset of the symptoms, reports of prior incidents similar to this, a chest x-ray was not warranted.
6. In the case of MRN #753211, a 17 year old female was seen for complaints of chest pain and a history of the flu. It was noted in the triage notes that she recently had a chest x-ray. Her primary care physician faxed over a radiology

report and office chart notes that showed a chest x-ray from just the day before was normal. In the case of an otherwise healthy 17 year old with a normal chest x-ray from the previous day, a second chest x-ray would have been superfluous and contraindicated due to unnecessary radiation exposure.

7. In the case of MRN #1038797, a 24 year old female with no prior medical or surgical history and who was otherwise healthy presented to the ED with intermittent chest pain "for years," previously diagnosed as spasms. The patient's chest pain was worse with movement and was "never" associated with shortness of breath or difficulty breathing. In addition, she had no abdominal or back complaints. An EKG was performed which was normal. Under the circumstances of a young, healthy patient with no prior medical history and a normal EKG with reported intermittent chest pain for years, no chest x-ray would be necessary.

8. In the case of MRN #107228, a 36 year old pregnant female reported chest pain, palpitations, and dizziness. She had diabetes mellitus (type 2) that was uncontrolled. X-rays are relatively contraindicated during pregnancy, and therefore unless absolutely necessary, no chest x-ray should have been performed on this patient. I note that she had 2 EKG's that were normal as well as a normal cardiac troponin. Obstetrical consult felt that the pain was musculoskeletal in nature. Again, in this patient, where a chest x-ray was contraindicated due to pregnancy, a chest x-ray was not indicated, especially in light of her age, lack of any cardiac history, two normal EKG's, and negative Troponin.

9. In the case of MRN #818403, this 60 year old male patient with a history of MI presented with epigastric pain and nausea. He denied crushing chest pain and stated that it felt exactly like his MI from two years prior. In light of this history and an EKG that showed a right bundle branch block "worse than his previous EKG," he was taken "emergently" to the cardiac cath lab. Similar to MRN #1161066 above, any chest x-ray would have been superfluous when the patient is taken immediately to the cath lab where fluoroscopy (x-ray) films of the chest would be part of the procedure.

10. In the case of MRN #333116, a 48 year old female presented for left "lung" pain with a recent history of atelectasis and requesting pain medication. She was just discharged from the hospital two days prior with this diagnosis. Drug-seeking behavior was on the differential. She was given a prescription refill and advised that it was not appropriate to use the ED for prescription refills. No orders were entered for this patient. This was a request for pain medication refill from a patient who obviously had had chest imaging in the days prior. Any chest x-ray would have been unwarranted and superfluous.

11. In the case of MRN #236533, an 87 year old female presented with left rib pain following a fall the night before. She had just been released the day prior from the hospital where she was being treated for chest pain. She reported no "anterior chest pain" and reported "no other chest pain." Her symptoms were reported to be "all pain related to the fall." Plain films of the ribs were ordered which imaged to the patient's shoulder. In this case, where the patient was just released from an inpatient stay where she was being treated for chest pain, where chest imaging was most certainly done, and the pain was directly from a fall assessed with rib films, a chest x-ray was not warranted.

12. In the case of MRN #1375381, a 51 year old male presented with a 1 week history of left lower quadrant abdominal pain who developed chest pain that morning while drinking a glass of juice. He reported no radiation of the pain, no shortness of breath, no nausea, and no past medical history other than an

unspecified orthopedic shoulder problem. He described his chest pain as "burning." His cardiac enzymes were normal and his EKG was unremarkable. His chest pain returned while in the ED and he was therefore admitted for a cardiac stress test. In this case, a chest x-ray would have been appropriate, but was not required, in a patient with no cardiac history, normal EKG, normal enzymes, and no reported risk factors for cardiac etiology.

In reviewing these 14 charts, 5 of the patients had imaging that included the chest (three CT scans and two rib series x-rays). Therefore, excluding Mr. Strimber, 212 or 96% of patients with any complaint of chest pain, even when it was not their primary complaint, received some form of chest imaging. Of the remaining 9 individuals, other than Mr. Strimber, two were taken urgently to the cath lab making a chest x-ray unnecessary and superfluous. Of the 7 remaining, 6 were significantly younger than Mr. Strimber and were otherwise healthy individuals who had no prior cardiac medical history. Moreover, every patient older than 60 received some chest imaging, excluding patients taken directly to the cath lab where fluoroscopy films would have been obtained. Also note that Dr. Fisher was the attending for 8 patients other than Mr. Strimber, whose ages ranged from 13 to 85. 8 out of 8, or 100%, of his patients other than Mr. Strimber received a chest x-ray.

It is my understanding there is no written policy, and I have not seen any policy, of Abington Memorial Hospital regarding the standard screening examination to be given to patients who present to the ED with a complaint of chest pain. The only policy is an order set used by nurses when a physician is not available to see the patient which requires a chest x-ray to be ordered for patients with chest pain. However, based upon my review of the 222 charts provided by Abington spanning a 4 week period of time, it is clear that the standard screening evaluation for patients who present with a triage chief complaint of chest pain at the Abington Memorial Hospital Emergency Department includes a chest x-ray or other chest imaging. Mr. Strimber did not receive the usual level of screening evaluation afforded to other chest pain patients in this ED. Because Mr. Strimber did not receive the same basic screening examination given to similarly situated patients with comparable complaints during this 4 week period of time, Abington Memorial Hospital, to a reasonable degree of medical certainty, violated EMTALA.

The opinion rendered is based on my experience and training as an emergency physician over the past 23 years. During this time I have practiced emergency medicine at multiple high volume, high acuity referral centers that care for patients with similar complaints. I have rendered care to thousands of patients with a chief complaint of chest pain. My opinions are also based on my experience as a clinical investigator who has performed original research on the care of patients with chest pain and related complaints and diagnoses. The opinion is based on the totality of information provided. I have no specific legal training or legal expertise in the field of emergency medicine, or otherwise. I reserve the right to amend this opinion based on any additional information that may become available.

Keith A. Marill, M.D.

EXHIBIT "O"

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Heather Tereshko, Esq.
Christie Pabarue and Young
1880 John F. Kennedy Blvd, 10th Floor
Philadelphia, PA 19103

September 19, 2014

Re: **Estate of Abraham Strimber v. Abington Memorial Hospital, et al.**

Dear Ms. Tereshko:

I have reviewed the following additional materials with regard to the above matter:

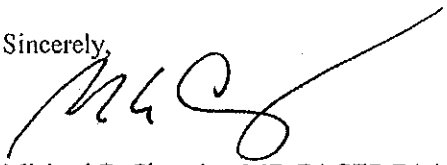
1. Abington Memorial Hospital Emergency Trauma Center Policy: ETC, regarding Myocardial Infarction.
2. Abington Health Nursing Policy, Number 14.53, regarding EMTALA;

You have asked me to review these additional documents with specific attention to the care rendered to Mr. Abraham Strimber at the Abington Memorial Hospital (AMH) Emergency Department on Wednesday February 22, 2012.

I stand by my previously stated opinion that there was no violation of EMTALA by AMH with respect to the treatment provided to Mr. Strimber on February 22, 2012. There is no medical screening evaluation for patients with chest pain, beyond a thorough history and examination by the emergency room physician. It is clear from my review of the records that Mr. Strimber was evaluated thoroughly by three competent physicians, and two well-trained emergency room nurses, during his time at AMH and he repeatedly denied chest pain to each of these individuals. A chest radiograph is NOT part of a medical screening evaluation, specifically in a patient not complaining of chest pain.

None of these additional policies change my initial opinion as stated in my report dated September 4, 2014. I continue to find that the care rendered to Mr. Strimber by the Abington Memorial Hospital Physician and Nursing Staff on February 22, 2012 was within the standard of care, and in no manner violated EMTALA. Again, all of my statements and opinions are made within a reasonable degree of medical certainty. I'd be happy to review additional materials, and will certainly make myself available in the event this action should go to trial.

Sincerely,



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